October 7, 2002

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House of Representatives

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Olympia, WA 98504

Mr. Harold Nelson
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Olympia, WA 98504

Mr. Tim Yowell
Ways and Means Committee

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Olympia, WA 98504

Mr. Doug Porter

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Olympia, WA 98504

Dear Amy, Tim, Harold and Doug:

As the first deliverable in our contract with Washington State, we are providing you with an inventory of the current cost containment activities underway in the Medicaid program. We will follow-up with a hard copy of this report, via Federal Express, to arrive at your offices tomorrow.

The Lewin Group sent a draft version of the "Inventory of Washington Medicaid Cost Containment Activities" for review on Friday, September 27, 2002, and received several comments and suggestions during the week of September 30, 2002. As you will see in the final document, we made numerous changes, per your suggestions, as follows:

- Changed the format so the document is organized by topic: UCCI activities, other legislative directives, other new activities, and ongoing strategies. This will make the inventory more "user friendly" and will distinguish older, ongoing projects from newer activities;

- Clarified savings associated with UCCI vs. baseline savings from prior activities;
- Added an introduction to better explain the purpose of the inventory and to clarify information contained in the tables;
- Included the time period covered by the savings estimate, the portion of savings that are State funds, and the source of the estimate;
- Added projects focusing on quality review of pharmacy, medical and dental to the inventory;
- Changed the HIFA estimated savings, based on the information contained in the HIFA waiver application;
- Changed the implementation date of the hospital selective contracting, based on the CMS "waiver fact sheet";
- Renamed the drug discount project and revised the language in it to read "at least four generic labels";
- Revised interpreter services activities to correctly reflect the two projects underway: brokerage service and increased utilization review;
- Included the new rate of $197.45 for kidney dialysis;
- Removed mail order pharmacy from the listing of "UCCI" activities, but still included it in the inventory as a cost containment strategy;
- Removed administrative reductions from the list of UCCI activities. As we noted in the introduction to this report, we are focusing on savings in program expenditures rather than administrative costs. Per MAA's request, we have removed savings associated administrative reductions, consistent with the focus on program expenditures;
- Added information on Schedule 2 drugs and injectibles under the Pharmacy Maximum Allowable Cost (MAC) pricing project;
- Entirely deleted supplemental pharmacy rebates from the inventory. Based on an update from Siri Childs at MAA, CMS has approved Washington's supplemental rebate template, and Washington is currently writing the required Washington Administrative Code (WAC) to implement the project, but it is not yet close enough to implementation to warrant inclusion in the inventory; and
- Deleted the reduced vendor rates from the inventory as this initiative applies to all human services contractors, not just to MAA or Medicaid.

In addition to the comments above, DSHS and legislative staff suggested some changes we were unable to incorporate into the final report. First, we were unable to include: a) specific examples of services and supplies for which the maximum allowable fees were changed and b) clarification of the savings calculations for mail order pharmacies. While MAA staff pursued this information for us, answers were not available in time for inclusion in this report. We will continue our work to clarify these items as our project continues.

There was also a suggestion that all estimates cover the same time period. Based on the information collected and conversations with State staff, we are unable to provide estimates for a consistent time period at this stage of our engagement. For example, some savings estimates like those for the disease management contracts are estimated as a percentage of current costs. Other programs are too new to have estimates. Finally, some programs are able to provide already realized savings, which we have included rather than savings estimates. We included in the introduction to the inventory the limitations of the reported savings column.

Finally, we were asked about the status of quality reviews that may potentially detect hospital Diagnosis Related Group (DRG) upcoding. This project is currently under development and has not realized any savings for fiscal year 2002. Therefore, we have not included hospital DRGs in our list of quality review activities.

We greatly appreciate the thoughtful and timely feedback we received from all of you. Should you have any questions after reading the inventory, please feel free to call me at (703) 269-5627.

Best regards,

Charles J. Milligan, Jr.

Vice President

Encl.

LEWIN REPORT No. 1

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I. INTRODUCTION

Over the past several years, the Medical Assistance Administration (MAA) has undertaken a variety of activities to contain costs within the Medicaid program. Some of these activities are part of a program entitled the "Utilization and Cost Containment Initiative" (UCCI), which was legislatively mandated in the 2001/03 biennial budget. The activities under UCCI were designed to achieve approximately $50 million in state savings over the biennium. One central feature of UCCI is the establishment of a baseline against which MAA is to measure its savings, to demonstrate that MAA met the budgetary target. It is important to note, however, that MAA's Medicaid cost containment strategies are not limited to UCCI and have occurred in other program areas.

The attached Inventory describes the Medicaid cost containment activities. It describes the current cost containment strategies that have realized savings in recent years, providing a foundation from which to build additional strategies.

A. Methodology for Data Collection

The Lewin Group took several approaches to gather information for this Inventory. First, we conducted a preliminary search of documents available on various websites, including Washington's Department of Social and Health Services (DSHS) and the Centers for Medicare and Medicaid Services (CMS) sites. Through our search, we were able to obtain background on the structure of Washington's Medicaid program and current budget and forecasting estimates, including estimates of the projected savings from certain cost containment activities.

Following this initial data gathering and review, we were able to create a preliminary data request, which we submitted to DSHS on September 6, 2002. After refining our request during a subsequent conference call, DSHS provided us with several electronic files documenting some of Washington's current cost containment activities. We reviewed these files in preparation for our on-site interviews on September 17th and 18th.

During our on-site interviews, we met with several members of DSHS and legislative staff to clarify current cost containment activities and to explore areas where additional cost containment activities may benefit Washington. We met with DSHS staff from the following program and functional areas:

- UCCI
- Information Services
- Medical Management/Quality Review
- Budget
- Forecasting
- Managed Care
- Long Term Care
- Policy Analysis/HIFA Waiver
- Pharmacy

Based on our own data collection and the information DSHS provided to us through electronic files and interviews, we have compiled the following inventory of current cost containment activities.

B. Format of the Inventory

The Inventory is provided in table format and is divided into four sections that categorize the type of cost containment activities included. For each activity, the following information is provided:

- **Project** - For each activity, we have provided a title to identify the major focus of the activity.

- **Description** - The description provides an overview of the cost containment strategies employed within each project or activity. It also details the method for achieving cost savings (e.g., streamlining administrative functions or preventing erroneous payments).

- **Project Start Date** - Where possible, we indicated the effective date of implementation for each activity. For some projects, however, the implementation date cannot be specifically determined. For example, coordination of benefits (COB) efforts have been ongoing throughout the history of the state's Medicaid program. While these COB efforts do not have a specific effective date, the intensity of the activities substantially increased as a direct result of the UCCI.

- **Reported Savings** – Through collecting materials and conducting interviews, we obtained estimates of projected savings/cost containment. For each activity, the total savings and state savings are noted, as well as the time period for which the savings are applicable. While it would be most useful to the reader if all projected savings related to the same time period, the information reported to us did not align in this way. Additionally, some of the savings amounts are actual realized savings, while others are budgeted amounts or other types of estimates. Therefore, these savings cannot be added together to form a cumulative savings amount. Finally, the savings estimates do not include adjustments for administrative costs associated with the cost containment activities. All of these issues (different periods; cannot add savings; no adjustments for administrative costs) are due to the fact that, for purpose of this Inventory, we simply are reporting the information provided to us. In subsequent phases of this project, when Lewin applies our own analysis, we will attempt to address these issues.

- **Source(s)** – For each activity, we have outlined the source(s) from which we obtained the information displayed in the table.

The inventory is divided into four major types of cost containment activities:

- **UCCI Activities** – In the 2001-2003 biennial budget, the UCCI was required to demonstrate savings of $50 million in state funds. The section includes projects that were undertaken as part of this effort.

- **Other Legislative and Budget Directives –** These activities were required as part of the 2001/2003 biennial budget or as part of the 2002 supplemental budget, but were not specifically included in the UCCI.

- **Other Initiatives –** These initiatives were undertaken by MAA to contain costs but are neither part of UCCI nor mandated by the legislative budget process.

- **Ongoing Long Term Strategies –** These activities have been in place as cost containment measures for several years. Historically, states have implemented these kinds of measures for long-term cost containment.

II. UCCI ACTIVITIES

Project	Description	Project Start Date	Reported Savings	Source(s)
Adjust Maximum Allowable Cost Fees and MMIS Threshold	Currently in the Fee-For-Service (FFS) rate schedule there are many services and supplies, such as durable medical equipment, for which the provider can be reimbursed at or near acquisition cost. MAA's Rates Development Unit works in conjunction with program and Information Systems staff to research, establish and implement fee schedules. Although the Medicaid Management Information System (MMIS) currently checks a claim against a maximum allowable fee limit, many maximums have merely been updated from year to year by the vendor rate increase. The maximum allowable fees need to be adjusted downward to more accurately set a ceiling for a provider's likely acquisition cost. The result of maximum allowable fee adjustments will be that the MMIS will flag incorrect billings, thereby avoiding overpayments, which would otherwise be identified only through an audit or quality review.	Re-pricing underway currently	Savings not estimated	UCCI 9/02 report to the legislature (p. 13)

Project	Description	Project Start Date	Reported Savings	Source(s)
Alternative Payers – Veterans Administration (VA)	In May, 2002, MAA stopped paying for pharmaceuticals for Washington's Medicaid-eligible veterans in VA nursing homes, based on the VA's obligation to be primary insurer. MAA is now exploring the means to also hold the VA accountable for the cost of drugs for Medicaid-eligible veterans residing in any nursing home in Washington.	5/02	$116,600 ($57,780 State) in estimated savings for May and June 2002, from UCCI preliminary FY02 4th quarter results	UCCI 9/02 report to the legislature (pp. ii, 5)
Audits (Hospital and Medical/ Dental Providers)	MAA recently increased its staffing to recover more overpayments to hospitals and independent practitioners, through increased audit activities. The hospital audits address: provider claims for services, third-party liability, spend down amounts paid by the client to the provider but not offset in the provider's Medicaid claim, hospital-based physician claims, and ambulatory surgery center claims. The Medical Audit Unit is responsible for auditing many provider types including physicians, dentist, pharmacies, medical equipment providers, Federally Qualified Health Centers, and others.	Audits on-going. Increases in completed audits for FY02. Anticipated increases in FY 03.	FY02 recovered $11.76 million ($5.83 million State funds) This includes baseline savings of $2.7 million ($1.34 million State)	UCCI 9/02 report to the legislature (pp. 4, 9)

Project	Description	Project Start Date	Reported Savings	Source(s)
Coordination of Benefits (COB)	MAA recently increased its staffing and changed its policies to avoid paying claims where the Medicaid beneficiary has other coverage. COB staff have the primary responsibility to: identify third-party commercial insurance resources, recover Medicaid payments made to clients who have third-party commercial insurance, and resolve suspended claims that have third-party insurance resources. Once a potential COB source has been verified, it is added as an identifier to the MMIS, and all claims that MAA has paid during the coverage period are automatically identified and added to the billing file. COB staff edit and work the billing file so that appropriate invoices (within timely filing limits) can be generated and mailed to carriers, providers, etc., to recover funds.	COB activities ongoing. Additional efforts began in FY02.	$115.5 million ($57.2 million State funds) in FY02 This includes baseline savings of $87.9 million ($43.5 million State)	UCCI 9/02 report to the legislature (pp. 4, 13)
Increased Monitoring of Interpreter Services	DMM will initiate pre-payment claims review. This will reduce payments and increase recovery of inappropriate billings.	FY02	Estimated savings of $375,000 ($186,000 State)	UCCI 9/02 report to the legislature (p. 12)
Kidney Dialysis Rates	In September 2002, MAA began paying significantly lower rates for dialysis than in past years. Prior to September 2002, MAA reimbursed kidney centers at the amount they billed. Going forward, MAA will begin paying freestanding centers $197.45 per dialysis treatment (about 65 percent of previous average reimbursement, with legislatively authorized adjustments in future years).	9/02	$3 million ($1.5 million State) in FY03	UCCI 9/02 report to the legislature (pp. ii, 5, 13) Additional information provided by Dick Hancock

Project	Description	Project Start Date	Reported Savings	Source(s)
Medicare Eligibility and Third Party Liability	DSHS is working to identify Medicaid clients who may be eligible for Medicare to ensure that Medicare is billed for eligible services before Medicaid pays for them. Specific attention is being focused on ESRD patients and people who were disabled before age 22 and are eligible for Medicare coverage under their parents. The CMS Medicare Enrollment Database (EDB) database is also being used to cross-reference possible dual eligibles. MAA has found that the time it takes for certain Medicaid clients to become Medicare eligible can be reduced. Once Medicare is approved, coverage is retroactive to the date of the client's application. Expedited Medicare application and eligibility is being developed by MAA on a pilot basis.	Ongoing	Savings not estimated	UCCI 9/02 report to the legislature (pp. ii, 5)
Non-emergency Medical Transportation Program	MAA assures access to necessary non-emergency medical services for all eligible clients. MAA contracts with nine brokers who screen clients and arrange the most appropriate, least costly method of transportation. Statewide in FY01, MAA provided 2,030,000 trips. To improve control of utilization and cost, MAA has implemented the following changes: in Pierce County, MAA started a new contract for brokerage services in order to take advantage of local price and services competition; in King County where public transportation is generally available, MAA restructured screening and trip-distributing processes to ensure clients are being assigned to lowest cost, appropriate, transportation services.	Early 2002	Estimated savings of $1.3 million ($647,000 State) for FY02	UCCI 9/02 report to the legislature (p. 12)

Project	Description	Project Start Date	Reported Savings	Source(s)
Pharmacy Preferred Drug List (PDL)	A PDL is a list that identifies a preferred drug (or drugs) within a therapeutic drug class. A preferred drug is selected by a group of independent practitioners because it is equally safe and effective when compared to the other drugs in that therapeutic class, and is the best value among these options. The preferred drug may be prescribed without prior authorization, but the non-preferred drugs require prior authorization. This process drives providers to increasingly prescribe the preferred drug. This results in lower drug expenditures and over time, diminishes staff time spent performing prior authorization activities. Four drug classes were recommended for the preferred drug list (PDL): proton pump inhibitors, histamine H2 receptor antagonists, non-sedating antihistamines, and statin-type cholesterol lowering agents.	2/02	$2.4 million ($1.2 million State)	UCCI 3/02 report to the legislature (p. 4)
Quality Review - Durable and Non-durable Medical Equipment	The MAA Division of Medical Management (DMM), Durable Medical Equipment Unit, has responsibility to prior approve, deny, or request additional provider/client information in FFS for: durable medical equipment (DME), medical supplies, orthotics and prosthetics, dental services, and orthodontia. The unit provides cost avoidance through FFS utilization controls such as prior authorization, and post-payment review of claims for services and equipment. The unit has recently increased its efforts for cost containment by focusing on implementing controls for services that presently do not require prior authorization, or that permit expedited authorization.	Ongoing	FY02 savings: $.9 million ($.45 million State)	UCCI 9/02 report to the legislature (p. 9)

Project	Description	Project Start Date	Reported Savings	Source(s)
Quality Review – Medical/Dental Program	The Division of Medical Management (DMM) has responsibility to approve, deny, or request additional provider/client information in FFS for medical and dental services. The UCCI Medical project include post pay review of hospital stays. The UCCI Dental project focuses on individual dental provider reviews and program improvements.	Ongoing	FY02 savings: $4.65 million ($2.3 million State) This includes baseline savings of $2.4 million ($1.2 million State)	UCCI 9/02 report to the legislature (p. 12)
Quality Review – Pharmacy Program	The MAA Division of Medical Management (DMM) is the quality review program that has responsibility to prior approve, deny, or request additional provider/client information in FFS for prescription drugs. The DMM unit has recently increased its efforts for cost containment by focusing on implementing quantity, age and gender limits on drugs (via computer edits) and by expanding the number of drugs that require prior authorization, or expedited prior authorization.	Ongoing	FY02 savings: $5.5 million ($2.7 million State) This includes baseline savings of $2.47 million ($1.23 million State)	UCCI 9/02 report to the legislature (p. 9)

Project	Description	Project Start Date	Reported Savings	Source(s)
Take Charge (Family Planning) Waiver	Take Charge is a 5-year family planning demonstration waiver that expands eligibility for Medicaid pre-pregnancy family planning services for women and men with family incomes below 200% of the poverty level. It has a limited benefit package. Outreach for the program has resulted in increased Medicaid enrollment. A goal of the Take Charge program is to decrease the number of unintended pregnancies and reduce the costs associated with maternity care. Upfront program costs (expansions, services) are intended to avoid long term expenses such as labor and delivery and increased enrollment of children in Medicaid.	7/01	Savings estimates expected end of 2002	UCCI 9/02 report to the legislature (pp. 4, 14)
Therapeutic Consultation Services (TCS)	TCS is designed to facilitate the involvement of the critical participants in the administration of drug therapy – the prescriber, the pharmacy and the patient. The TCS process monitors the prescribing practices of physicians and the drug usage of patients to ensure that the most cost effective drugs are being prescribed. It is initiated under two circumstances: when a claim for a non-preferred drug is submitted, or when a recipient exceeds four brand name prescriptions per month. Regardless of which of the two circumstances initiate the process, the prescribing physician must call the TCS call center which initiates the drug consultation process. See PDL above for further explanation.	2/02	FY02 Goal of $10 million ($5 million State)	UCCI 3/02 report to the legislature (p. 4) Additional information provided by Dick Hancock

III. OTHER LEGISLATIVE AND BUDGET DIRECTIVES

Project	Description	Project Start Date	Reported Savings	Source(s)
Disease Management	The Disease Management program follows an 01-03 Operating Budget directive to "design, implement, and evaluate pilot projects to assist individuals with at least 3 different diseases to improve their health." Two service providers will contract with MAA: Renaissance will service end stage renal disease (ESRD) and McKesson will service asthma, congestive heart failure (CHF) and diabetes. Objectives include: establish medical homes, reduce overall medical expenditures, and coordinate care across DSHS divisions. McKesson has enrolled approximately 4,000 recipients into the asthma project, roughly 50% of the targeted population. Renaissance has enrolled about 150-200 recipients in the ESRD project.	Enrollment: 4/02 (ESRD and asthma) 8/02 (CHF and diabetes)	Per disease management contract, contractor required to provide a guarantee of savings in overall medical costs: 5% for ESRD and asthma 1.7% for CHF and diabetes	UCCI 9/02 report to the legislature (pp. 4, 13) Contracts with McKesson Health Solutions LLC and Renaissance Health Care, Inc.

Project	Description	Project Start Date	Reported Savings	Source(s)
Emergency Room Copays	DSHS added a $3 co-payment for clients when they use hospital emergency rooms for treatment of non-emergency medical conditions. The goal is to discourage over-utilization of more expensive emergency room services.	7/02	$372,000 ($184,000 State) estimated for 01-03 biennium (based on 1/1/02 start date)	2001 Washington State Legislative Budget Notes Document outlining UCCI-Related Washington Admin. Codes (WACs) (p. 1)
Interpreter Services Efficiencies	The 2002 budget states that the current method of purchasing interpreter services is to be replaced with a new brokerage model by January 2003, for all DSHS programs. Under the new brokerage model, DSHS will contract at a specified rate with any qualified individual or agency, and will also contract with intermediaries who will schedule and link interpreters with clients and service providers. It is anticipated that this will result in cost savings because it will allow DSHS to set specified rates in advance and contract with providers at those rates.	Full implement-ation expected 1/03	$1.75 million ($.84 million State) in budgeted savings for FY03	UCCI 9/02 report to the legislature (p. 2)

Project	Description	Project Start Date	Reported Savings	Source(s)
Mail Order Pharmacy Services	The 2002 budget requires that Medicaid begin providing a mail-order pharmacy option for its clients. Due to pharmacies withdrawing from Medicaid as a result of the drug reimbursement decreases, MAA implemented the program with Medco Health Solutions in September 2002. It is anticipated that this will save money by decreasing the dispensing fee by providing three-month supplies of maintenance medication, and by realizing the lower cost of drug ingredients available via mail order.	9/02	$2.7 million ($1.43 million State) in budgeted savings	UCCI 9/02 report to the legislature (pp. ii, 1, 2, 5) Additional information provided by Dick Hancock
Reduce Length of Stay in GA-U Programs	The DSHS Economic Services Administration is to make a number of administrative changes which will reduce the average length of stay for persons in the General Assistance for the Unemployed (GA-U) Program. This is expected to reduce the number of persons who receive state-funded medical assistance as a result of their GA-U enrollment by one-third by the end of FY03.	7/02	$5.6 million total (all State funds) budgeted savings in 2002 supplemental budget notes	2002 Washington State Legislative Budget Notes

Project	Description	Project Start Date	Reported Savings	Source(s)
Reduce Prescription Drug Payment Rates	As a result of legislative action in 2002, Medicaid increased its discount and now pays 86% of the average wholesale price (AWP) for single-source drugs and 50% of the AWP for drugs for which there are at least four generic versions.	8/02	For FY03, budgeted savings of $24.4 million total ($12.4 million State)	2002 Washington State Legislative Budget Notes UCCI 9/02 report to the legislature (p. 9)
Reduction in Outpatient Rates in Anticipation of Outpatient Prospective Payment System (OPPS)	OPPS is a payment mechanism which pays for a "bundle" of procedures typically associated with a particular condition rather than for each specific procedure. Implementation is expected to reduce Medicaid outpatient expenditures by approximately 6%, but it has been delayed since April 2000 in order to minimize the burden on hospitals by assuring that the state system is consistent with the one required by the federal Medicare Program. Implementation now is not expected until April 2004. To compensate for this, an across-the-board reduction in outpatient rates is to be implemented to approximate the savings which would occur had the system been implemented.	7/02	$2.1 million ($1.06 million State) budget savings in state funds for FY03	2002 Washington State Legislative Budget Notes

Project	Description	Project Start Date	Reported Savings	Source(s)
TANF Transitional Medicaid Premiums	Families who receive transitional Medicaid (extended medical coverage after their TANF cash assistance is terminated due to excess income) will be required to pay health insurance premiums. Although there is an administrative cost associated with collection of premiums, the premiums will offset the state's cost of providing health care to these beneficiaries. Additional savings will result from a decrease in enrollment.	5/02	$5 million ($2.46 State) budgeted savings for 01-03 biennium	2001 Washington State Legislative Budget Notes

IV. OTHER INITIATIVES

Project	Description	Project Start Date	Reported Savings	Source(s)
Health Insurance Flexibility Act (HIFA) 1115 Demonstration Waiver	Washington has submitted a waiver to the Centers for Medicare and Medicaid Services (CMS) for approval to allow the state to implement several cost savings and containment techniques in its Medicaid program. To maintain budget neutrality, a CMS requirement, the waiver will not cover any new eligibility groups or services. The major provisions of the HIFA proposal are: A five-dollar copayment requirement for all Medicaid clients who choose a brand-name drug when a generic or preferred drug is available. This will save money by discouraging use of more expensive, but not better performing, drugs; A ten-dollar copayment requirement for all Medicaid clients who seek hospital emergency room services for non-emergent conditions. This will save money by discouraging use of costly emergency room services in place of less-costly physician office visits; The imposition of premiums on the categories of optional children, medically needy aged, blind, and disabled and medically needy pregnant women and children with family income above 100% of poverty. This will save money by helping to offset the cost of insuring these populations; The elimination of non-emergent dental, routine vision, and routine hearing benefits for adults in optional Medicaid	Submitted for CMS approval 8/02	Estimated for FY04 Savings : $2.5 million ($1.2 million State) from benefit changes Revenue: $1.75 million ($0.88 million State) from co-pays and $26 million ($13 million State) from premiums	HIFA Waiver Application

Project	Description	Project Start Date	Reported Savings	Source(s)
	buy-in, aged, blind, and disabled, and pregnant women; The imposition of an enrollment freeze in categories of optional children, medically needy aged, blind, and disabled, medically needy pregnant women and children, and SCHIP when expenditures for the entire Medical Assistance program are projected to exceed the forecasted level in annual appropriations; and The use of unspent Title XXI allotment to expand access for parents of Medicaid and SCHIP children and childless adults through the Basic Health Program. This will allow the state to maximize federal funding for health coverage.			
Payment Review Program	In FY00, DSHS began using a Decision Support System (DSS) that created a data warehouse. This provides vastly improved capabilities for searching claims data for overpayments and to identify potential fraud and abuse through profiling Medicaid clients' service utilization and provider claims. The Payment Review Program has realized savings through both recovery of overpayments and cost avoidance. The DSS is being utilized by MAA to detect fraud and to profile providers and clients by looking outliers of service use compared to their peers. Use of DSS is increasing MAA's ability to recoup funds and also allows for future cost avoidance.	FY2000	FY00 = $55,517 FY01 = $2.0 million ($1 million State) FY02 = $3.2 million ($1.6 million State) (Savings booked by MAA audit teams)	DSHS Payment Review Program Report to the Legislature 9/02 UCCI 9/02 report to the legislature (p. 6)

Project	Description	Project Start Date	Reported Savings	Source(s)
Washington Medicaid Integration Project (WMIP)	DSHS Secretary Braddock issued a memorandum in April 2002 to "initiate a department effort focused on Medicaid high utilizers." The goals of the project are to improve: client outcomes, cost effectiveness of services and community partnerships. A WMIP cross-agency team developed an implementation plan over the summer of 2002, suggesting a budget placeholder in September 2002, an RFP release for outside vendors to provide a system of care that includes case management and utilization review in November 2002, and contracts awarded January 2003. The WMIP recommends that DSHS implement promising proposals that serve small populations with targeted services and implement contracts that allow for no new funding and guaranteed savings. This project is expected to save Medicaid funds because it will encourage better care management for patients with complex needs and provide more appropriate utilization.	5/02	Savings not estimated	April 11, 2002 Memo from Dennis Braddock on "Coordinated Department Efforts to Address Medicaid High Utilizers" Washington Medicaid Integration Project – Implementa-tion Plan Executive Summary

V. ONGOING STRATEGIES

Project	Description	Project Start Date	Reported Savings	Source(s)
HealthyOptions	Washington's capitated managed care program helps to contain costs by allowing MCOs to utilize cost containment activities such as selective contracting and enforcement of utilization controls. The program requires mandatory managed care in 31 counties and voluntary enrollment in seven counties. Approximately 460,000 (51%) Medicaid beneficiaries are enrolled in managed care.	10/93	Estimated at $147 million from 2/01 to 2/03	CMS Waiver "fact sheet" for the State of Washingotn
Hospital Selective Contracting	Through a 1915(b) Freedom of Choice Waiver, Washington's FFS program is able to selectively contract with hospitals that agree to provide primary care services and inpatient care at an agreed upon rate. This waiver operates only in certain counties where provider over-capacity exists.	4/88	Estimated $4 million ($2 million State) in CYs 01 and 02	CMS website "fact sheet" for the State of Washington Additional information provided by Dick Hancock

Project	Description	Project Start Date	Reported Savings	Source(s)
Pharmacy Maximum Allowable Cost (MAC) List	The MAA DMM continually updates the MAC list for pharmacy but has not done a complete update of this list in five years. The MAC list is a pricing schedule for multi-source drugs within a therapeutic class. The state will pay the price of the least expensive drugs for all equal drugs in that class, resulting in cost savings. Determination of MAC pricing is labor intensive because it requires ongoing MAC pricing research to identify the therapeutically-equivalent multi-source drugs and then to document and maintain the schedule of prices. The MAA Rates Development Section also adjusted the schedule 2 drugs (narcotics) MACs to 89% of AWP in April 2002 and Medicare fees for injectibles.	Ongoing, since 1972	Savings not estimated for MAC adjustments other than the Schedule 2 drugs at $.75 million ($.37 million State) in FY02	Interview with Siri Childs and Ayuni Wimpee Additional information provided by Dick Hancock